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# **PART III**

## **EDUCATION AND PREVENTION**

## **20. YOUTH EDUCATION.**

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## Introduction

In January 1964, the report on smoking and health of the Advisory Committee to the Surgeon General of the Public Health Service was released. It presented to the public incontrovertible evidence that cigarette smoking was associated with disease. Major health professional organizations had already endorsed or committed themselves to educational programs against cigarettes (18). Several States had passed anti-cigarette resolutions urging the adoption of public health education in regard to the hazards of smoking; the Canadian Government had already begun to pursue a strong educational program against smoking (78). Since then, programs in the schools have proliferated, both in this country and abroad. Many state and local ordinances have required teachers to cover the facts on the negative effects of smoking on the body, but, in the absence of detailed information, we do not know in what ways educators have complied with these regulations. In any case, this chapter does not deal with the role of the educator, which is covered in a separate chapter, but reviews and discusses those antismoking programs directed toward youth that have been reported in the literature.

While many recommendations have been made for school programs and many programs have been described in the professional literature, there must be thousands that have never been reported. It is hoped that a comprehensive review can be made of ongoing programs, with a view toward describing them and selecting for review those that show promise of being effective in changing behavior. These, we hope, can be evaluated, and recommendations made for programmatic directions that appear to be potentially effective. There are many opinions concerning the relative effectiveness of various approaches, but few programs have been evaluated systematically. Thus, many recommendations for programs in schools are based on a general philosophy of education and others are based on studies specifically in the area of youthful smoking.

In the remainder of this section, we review some of the recommendations that have been made. Many are based on the belief that the greatest deterrent to smoking is knowledge of the adverse effects on health, others are based on the belief that attitude change is more important, and still others stress the influence of adult exemplars, peers, or both. Social and psychological components are discussed by some. Some recommend that all these facets be taken into account.

The second section of this chapter, which points to school programs reported in the literature, is divided into two parts. First, past and present school programs are described briefly. Second, three noteworthy programs are singled out for particular attention. In the first part, programs are divided into general programs, those that involve young people talking to other young people, those that involve physicians, and those that have an evaluation component.

In the third section, programs outside the formal education structure are touched upon, including those sponsored by voluntary health agencies and other organizations.

There follows a summary of the state of knowledge regarding smoking programs for young people. While many programs have been reviewed and discussed, it should be remembered that, in the absence of evaluative research, no one knows which programs are most effective, which subject matter material should be covered, or which approaches are most likely to yield desirable results. The chapter ends with general conclusions and recommendations.

### **Current Smoking Education Approaches**

Although recommendations for school smoking programs vary widely, one common goal, expressed either implicitly or explicitly, is maximal prevention of those illnesses related to cigarette smoking. It can be summed up by a statement that Secretary Califano made at the National School Health Conference in May 1977: "Effective health education early in life can help to prevent the major diseases of adulthood" (21). It is not surprising, then, that most recommendations emphasize the effects of smoking on health, long-term and immediate (1, 4, 18, 24, 46, 47, 48, 50, 59, 61, 95). However, there is increasing concern that facts alone are not sufficient to deter teenagers from becoming smokers. Some take the position that positive, favorable attitudes toward realization of the hazards of smoking are necessary. Where negative attitudes exist, efforts should be made to redirect them into positive ones and to affect behavior as well as attitudes. As Bynner pointed out at the Second World Conference on Smoking and Health, "there is good evidence from research into attitude change to suggest that an attempt to bring about change in a favorable direction on a combination of all these attitudes may be more effective than simply continuing to supply information about health risk alone" (20). Briney (16) found no significant relationship between knowledge of the effects of cigarette smoking and smoking behavior of high school seniors. Many have pointed out that youth imitates, and that one of the major influences is the example set by parents, teachers, health professionals, and other significant adults with whom the teenager is in contact. Thus, focusing attention on the exemplar is recommended (4, 48, 57, 62, 96, 101, 104). Closely related to the example which adults set for teenagers is the total environment, or climate, in which the adolescent finds himself. As Horn stated, "There are serious difficulties in attempting to influence young people by teaching them in the classroom to adopt behavior opposed to practices that are encouraged in the larger environment. Educators have found that smoking education programs in school meet with strong counterforces in television advertising and the smoking patterns of parents, other adults, and people youngsters admire in their own group" (54). A

number of people have addressed this problem and made suggestions for counteragents in the schools to cope with it (4, 20, 57, 96, 101, 104, 109). Although cigarette advertising no longer appears on television, it continues to be an accepted part of program content. Another area that is touched on by some is that of the social-psychological components of teenage smoking. Approaches here focus on the individual and personal behavior choices, recognizing the needs some believe cigarette smoking fulfills (4, 12, 24, 28, 29, 48, 50, 75, 101, 105). Many recommend taking all of these into account, as exemplified by the position statement of the American Association for Health, Physical Education, and Recreation (4).

### **School Programs**

School programs have usually followed one or more of the approaches outlined above, taking into account the health threat, the influence of adult exemplars, peer influence, or combinations of these. Many are one-time campaigns, with little or no evaluation. Because of this lack, it is impossible to report on the results or on the effectiveness of these programs. Only a few are carefully planned, long-term programs, with a systematic evaluation plan.

### **Past and Ongoing Programs**

In citing school programs, we have divided them into four categories: general, youth-to-youth, those involving physicians, and programs with strong evaluation components. General programs include both demonstration and long-term programs. Demonstration programs are those that are either one-time antismoking campaigns or innovative classroom procedures, as opposed to established programs that are or have been a part of the school curriculum. Long-term programs are those that extend over several years and include a large number of children. Youth-to-youth, physician, and evaluation component programs may also fit into these definitions, but they are discussed separately.

#### *General Programs*

##### **Demonstration Programs**

A number of original and imaginative techniques have been reported in the literature, including an experiment demonstrating to fourth-grade students the effect of tar on the lungs (10), use of students' questions to assist in the development of a health unit (17), a school survey conducted by students (33), construction of a model of a smoking man (67), construction of a train filled with empty cigarette packs (51), and a health fair put on by college students in an East Harlem junior high school (58). Other antismoking campaigns em-

ployed combinations of speeches, films, posters, and other exhibits (35, 56, 72).

It is difficult to assess the effectiveness of these programs since some reported no evaluation results (10, 17, 33, 58, 70) and others were assessed merely on the basis of students' reactions (51, 56, 67). Estrin, in 1965, compared responses of ninth- and tenth-grade students to a questionnaire administered before the campaign with responses to a questionnaire administered "several weeks after". There was no difference in the proportion of smokers, nor in the proportion of smokers who said they would be interested in trying to stop smoking, but there was a decrease in the number of cigarettes smoked. However, there was no control group with which to compare the results (35).

#### Long-Term Programs

Several programs that have reached a large number of children but have had no experimental-control evaluation are reported on in this section.

Surveys of smoking habits of students in grades 6 through 12 in Selah, Washington, were done in 1961, 1962, and 1964. Filmstrips were shown, literature was distributed, and an essay contest was held. After the first survey, results were reported to the students, stressing the fact that smoking students tend not to compete successfully athletically or academically, nor do they participate in extracurricular activities. Over the period of the program, the proportion of smokers at the junior high school level increased, but the proportion of smokers at the senior high school level stayed the same. The conclusion of the authors was that "an educational antismoking campaign defeats its purpose and actually increases the numbers who smoke" (2).

A program begun in Pennsylvania in 1962 placed emphasis on changing the social status of smoking. Much of the work was done through teachers and youth leaders. By 1967, 8,000 kits containing smoking and health information and resource materials for teachers and students and 10,000 copies of a teacher's resource unit had been distributed. A variety of pamphlets, posters, and audiovisual aids was prepared, regional meetings were held, and other activities such as school assemblies, exhibits, youth forums, and the like were planned. This effort was reported by Bohlayer (14).

A program initiated in 1968 in Monticello, New York, and designed to reach pupils in kindergarten through twelfth grade, featured a curriculum based on psychosocial needs of students, with emphasis on concept formation, attitude formation, and habit establishment. The program, funded for 3 years, was reported by Fleckman (39).

In Germany, a comprehensive campaign aimed at school children has been going on since the late 1960's. Newspaper articles, posters, and other means of conveying messages, such as badges, were tried.